

CLIENT TREATMENT PLAN

Short-term Goals / Objectives: Must be SMART: Specific, Measurable/Quantifiable, Attainable within this Treatment Plan review period, Realistic, and Time-bound. Must be linked to the client's functional impairment and diagnosis / symptomatology as documented in the Assessment.

Objective # _____	Assigning Date: _____
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Clinical Interventions: Must be related to the objective and achievable within the time frame of this Plan. Describe proposed intervention and duration (specify if time frame is less than 1 yr).

Type of Service: MHS* TCM Med Sup Crisis Res Trans Res Long-Term Res TBS DTI DR

Client Involvement Client agrees to participate by:	Family Involvement: <input type="checkbox"/> Biological <input type="checkbox"/> Other (If other, please specify below) Family is available <input type="checkbox"/> Yes <input type="checkbox"/> No Client consents to family participation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Family agrees to participate? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please specify)
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*MHS includes therapy/rehab (individual, family, or group), collateral and, in some instances, plan development services.

<p>This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.</p>	<p>Name: _____ IS#: _____</p> <p>Agency: Los Angeles County – Department of Mental Health Provider #: _____</p>
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